

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: **12/4/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/17/2013
Date of Injury:	2/5/2013
IMR Application Received:	6/24/2013
MAXIMUS Case Number:	CM13-0000804

- 1) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic two times a week for three weeks is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/24/2013 disputing the Utilization Review Denial dated 6/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic two times a week for three weeks** is not **medically necessary and appropriate**.

### **Medical Qualifications of the Expert Reviewer:**

The independent Expert Reviewer who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Chiropractic/Acupuncture, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

Claimant is a 38 year old female who was involved in a work related accident on 2/5/2013. The primary diagnosis is wrist sprain. The patient has had 12 chiropractic treatments and 12 physical therapy sessions. An MRI of the left wrist shows an equivocal low grade radial collateral ligament strain. Prior to the injection, the claimant had point tenderness along the left 2nd extensor compartments, and left dorsoradial wrist pain. The claimant had a cortisone injection to her wrist which improved her wrist pain. She has full range of motion with good grip and no tenderness of the left wrist as documented by her PTP on 10/1/2013.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for chiropractic two times a week for three weeks:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, manual therapy and manipulation, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation, pgs 58-60, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate that chiropractic therapy is not recommended for wrist conditions. The employee has already had extensive chiropractic therapy. Most of the chiropractic therapy was focused on the employee's neck and mid back. However the notes show that the chiropractor did attempt to treat the wrist with minimally sustained results. There was no functional improvement of the wrist as a result of chiropractic treatment. The employee is almost asymptomatic as documented by the Primary Treating Physician on 10/1/2013. **The request for chiropractic treatments two times a week for three weeks is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.